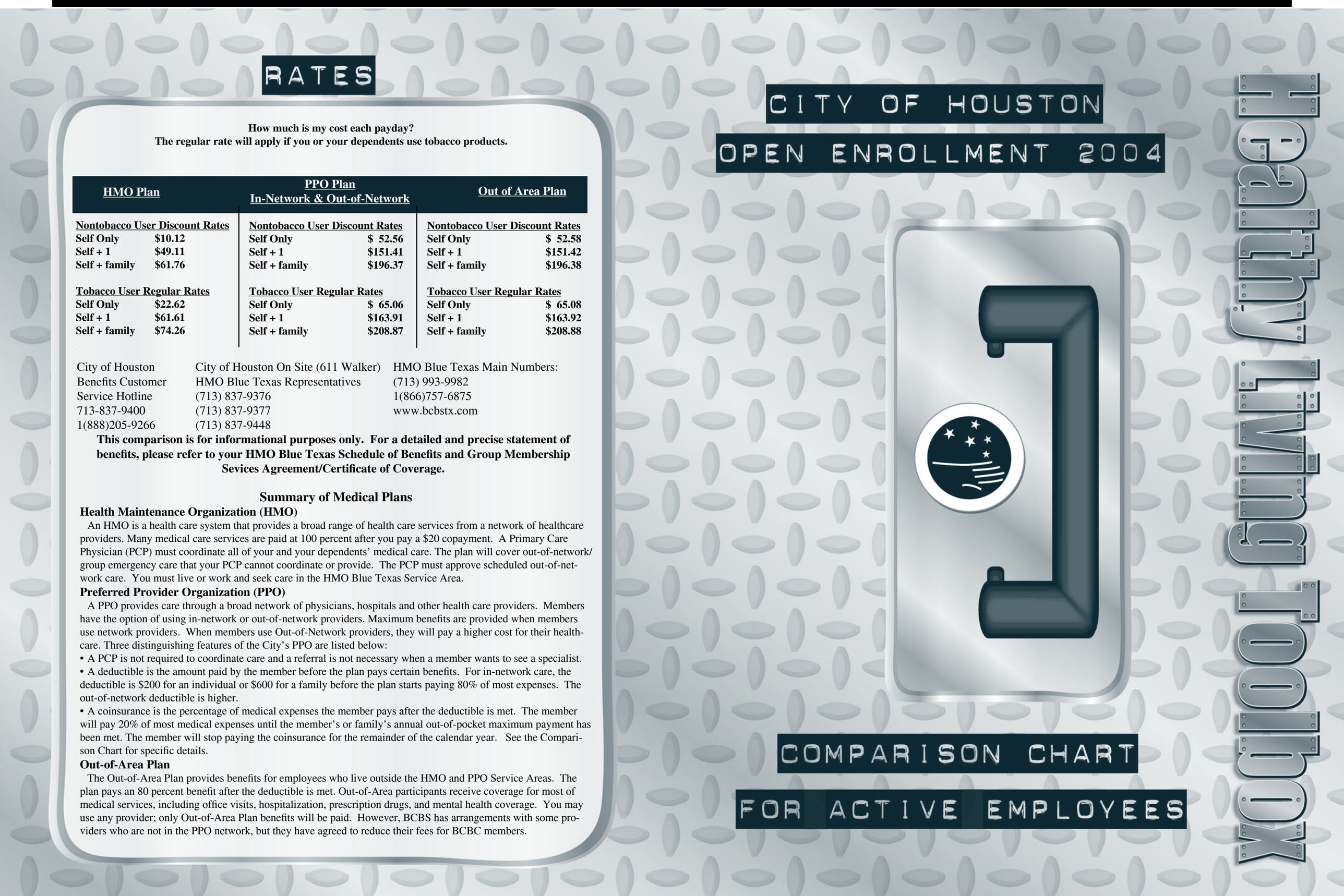
# City of Houston Medical Plan Comparison for Active Employees

| Coverage | HMO Plan | Preferred Provider Organization (PPO)<br>In-Network / Out-of-Network | Out-of-Area Plan |
|---|---|---|---|
| **Who is eligible to participate?** | Full-time, permanent employees and part-time employees regularly scheduled to work 30 or more hours per week and who reside or work in the HMO Blue Texas Service Area. View www. bcbstx.com to find a provider.<br>Retirees, if they were covered when they retired.<br>**The HMO Service Area is limited to Texas. 34 counties are not in the Service Area.** | Full-time, permanent employees and part-time employees regularly scheduled to work 30 or more hours per week and who reside or work in the PPO Service Area.<br>Retirees, if they were covered when they retired.<br>**The PPO Service Area includes 49 states; Montana is not in the PPO Service Area. Look for your zip code at www.bcbs.com.** | Full-time, permanent employees and part-time employees regularly scheduled to work 30 or more hours per week and who reside outside of the HMO & PPO Service Areas.<br>Retirees, if they were covered when they retired. |
| **Eligible Dependents:**<br>Legal spouse, unmarried dependent children under age 25 who are: 1) natural children and grandchildren, 2) step-children residing permanently with the employee, 3) legally adopted or children over whom an employee has legal guardianship and 4) unmarried dependent children over age 25 who were covered before age 19, mentally and/or physically handicapped and dependent on employee for 50% support. All dependents must be dependents for federal income tax purposes. Copies of a marriage license, registration and declaration of an informal marriage certificate (common law), birth certificates and/or other proof of parent/child relationship are required. Certification of Financial Dependency of Children form is required for grandchildren. | | | |
| **May I enroll myself and my dependents at a later date if I do not join the plan when first hired or during the Annual Open Enrollment?** | Enrollments are accepted only during the first 31 days of employment, within 31 days following a change in family status (i.e., birth of a child, marriage, etc.), during a city-sponsored open enrollment and within 31 days after an employee moves into the HMO service area. If enrollments are not timely, coverage will be subjected to a 90-day wait. **All such changes are subject to Section 125 guidelines.**<br>Retirees may not enroll after they retire. Covered retirees may enroll eligible dependents during a city-sponsored open enrollment, within 31 days following a family status change, and within 31 days after moving into the HMO Service Area not covered by the PPO or moves out of area. | Enrollments are accepted only during the first 31 days of employment, within 31 days following a change in family status (i.e., birth of a child, marriage, etc.), during a city-sponsored open enrollment and within 31 days after a person moves into the PPO Service area not covered by the HMO.<br>If enrollments are not timely, coverage will be subjected to a 90-day wait.<br>**All such changes are subject to Section 125 guidelines.**<br>Retirees may not enroll after they retire. Covered retirees may enroll eligible dependents during a city-sponsored open enrollment, within 31 days following a family status change, and within 31 days after moving into the PPO Service Area not covered by the HMO or moves out of area. | Enrollments are accepted only during the first 31 days of employment, within 31 days following a change in family status (i.e., birth of a child, marriage, etc.), during a city-sponsored open enrollment and within 31 days after an employee moves out of the HMO and PPO Service areas. If enrollments are not timely, coverage will be subjected to a 90-day wait. **All such changes are subject to Section 125 guidelines.**<br>Retirees may not enroll after they retire. Covered retirees may enroll eligible dependents during a city-sponsored open enrollment, within 31 days following a family status change, and within 31 days after moving out of the PPO & HMO Service Areas. |
| **Does the plan cover participants while out of the Service Area?** | Yes, but only in the event of an accident or medical emergency. HMO Blue Texas must be notified within 48 hours of initial treatment. **Services must be sought within 12 hours after the onset of symptoms of an illness or within 48 hours after an accident.** | Yes. Participants are covered at home or away, 24 hours a day, using their choice of physicians. A reduced benefit and higher deductibles apply for services obtained out-of-network.<br>If a participant initially seeks emergency care from other than participating providers, the care must be transferred to participating providers as soon as medically possible in order to continue to be eligible for In-network benefits.<br>To identify participating providers outside of Texas, call 1-800-810-2583 or use the zip code of where you are to find a provider at www.bcbs.com | Yes. Out-of-Area benefits will be paid for covered medical expenses.<br>Use www.bcbs.com to find a doctor who has agreed to provide discount fees to Blue Cross Blue Shield members. |
| **If I am now covered, will my current health problems be covered?** | Yes. If the plan now covers an illness or condition, the plan will continue to cover it. | Yes. If your prior city plan covered an illness or condition, this plan will continue to cover it. | Yes. If your prior city plan covered an illness or condition, this plan will continue to cover it. |
| **What are the annual individual and family deductibles?** | None. | **Individual**: $200<br>**Family:** $600 | **Individual**: $400<br>**Family:** $1,200 | **Individual:** $350<br>**Family:** $1,050 |
| **What are the annual combined coinsurance/ deductible maximum for the PPO? (add all coinsurance, deductibles and copayments)**<br>**What is the maximum annual copayment for the HMO?** | Individual: $1,500<br>Family: $3,000<br>Excluding copays for prescription drugs, inpatient mental health and other supplemental riders (eg. Vision care, prescription drug, durable medical equipment and inpatient medical health riders). | Individual: $3,000<br>Family: $6,000<br>Excluding copays for prescription drugs. | Individual: $5,000<br>Family: $10,000<br>Excluding copays for prescription drugs. | Individual: $3,000<br>Family: $6,000<br>Excluding copays for prescription drugs. |



# City of Houston Medical Plan Comparison for Active Employees

| Coverage | HMO Plan | Preferred Provider Organization (PPO) In-Network | Preferred Provider Organization (PPO) Out-of-Network | Out-of-Area Plan |
|---|---|---|---|---|
| **After I reach my annual out- of-pocket maximum, will I continue to pay any coinsurance or copayments?** | Yes. You will always pay the copayments for prescription drugs and any riders such as vision care, durable medical equipment and inpatient mental health. | Yes. You will always pay the copayments for physician office visits, prescription drugs, inpatient hospital stays, urgent care and emergency room services. | | |
| **What is the lifetime maximum benefit per person?** | None. | $1.5 million per participant.<br>Lifetime maximum does not apply to coverage or services for AIDS or Human Immune Deficiency Virus Infection. | | |
| **May plan participants select physicians, specialists, and hospitals of their choice?** | Plan participants may choose Primary Care Physicians and pharmacies that are in the HMO Blue Texas network. All care must be coordinated by your PCP. The PCP must refer to other providers and specialists who are in the same IPA as the PCP. Female plan members may self refer to OB/GYN in the PCP's group for their annual well-woman examinations.<br><br>Note: Changes in the selection of your PCP will be effective the first of the following month. | Plan participants may choose physicians, hospitals, pharmacies and other medical providers that are members of the PPO network. Contact BCBS for assistance in locating a provider or view www.bcbs.com.<br><br>Participants may choose a provider out-of-network and benefits will be paid at a reduced level. | Participants may select the provider, hospital or pharmacy of their choice. If the Provider is not in the PPO Network, the doctor may be a ParPlan provider contracted with BCBS to provide reduced or discounted fees. | Participants may select the provider, hospital or pharmacy of their choice. Out-of-Area benefit levels will apply. If the Provider is not in the PPO Network, the doctor may be a ParPlan provider contracted with BCBS to provide reduced or discounted fees. |
| **What does the plan pay for:**<br>**Prescriptions? (same benefit for all plans)**<br>If the physician prescribes or allows a generic drug, but the patient requests brand, the copayment will be the difference between the cost of brand and generic plus the generic copay. | 30-day supply<br>Generic Drug<br>Preferred Brand Name<br>Non-Preferred Brand Name | Participating Pharmacy<br>$10 copay<br>$30 copay<br>$45 copay | Non-Participating Pharmacy<br>50% after $20 copay<br>50% after $20 copay<br>50% after $20 copay | |
| | All maintenance prescription drugs prescribed for more than 30 days may be filled by Advance PCS Mail Order Program. Participants pay $20 for generic, $60 for preferred brand and $90 for non-preferred brand per 90-day supply. Mandatory generic unless written as "Dispense as Written." Find a local pharmacy at www.bcbs.com. | | | |
| **Periodic Physicals/Check-ups?** | 100 percent after $20 copayment. | 100 percent after $30 copayment in the physician's office. | 60 percent after annual deductible. | 80 percent after annual deductible. |
| **Office visits?** | 100 percent after $20 copayment. | 100 percent after $30 copayment. | 60 percent after annual deductible. | 80 percent after annual deductible. |
| **Well-Baby and Well-Child Care?** | 100 percent. Individual must be under age 18. | 100 percent after $30 copayment. | 60 percent after annual deductible. | 80 percent after annual deductible. |
| **Well-Woman Exam?**<br>**(includes mammogram age 50 and over or family history of breast cancer exists)** | Covered at 100 percent. (One exam per 12 months) | 100 percent after $30 copayment. | 60 percent after annual deductible. | 80 percent after annual deductible. |
| **Well-Man Exam?**<br>**(includes prostate examination & prostate specific antigen test-age 50 and over and for those persons age 40 with a family history or other prostate risk factors.)** | Covered at 100 percent. (One exam per 12 months) | 100 percent after $30 copayment. | 60 percent after annual deductible. | 80 percent after annual deductible. |
| **Colorectal Cancer Screening?**<br>**(Includes fecal occult blood test, a exible sigmoidoscopy with hemoccult of the stool and colonoscopy - members 50 or over or family history of colorectal cancer exists)** | Covered at 100 percent. (One exam per 12 months) | 100 percent after $30 copayment. | 60 percent after annual deductible. | 80 percent after annual deductible. |
| **Routine Immunizations?** | 100 percent before and after age 6. | 100 percent to age 6. After age 6, 100 percent after $30 copayment | 100 percent to age 6. After age 6, 60 percent after annual deductible. | 100 percent to age 6. After age 6, 80 percent after annual deductible. |
| **Vision, hearing and speech screenings?** | Covered at 100 percent.<br>**(Members under age 18)** | Eligible expenses for routine sight, hearing and speech screening covered 100% after $30 copay when performed by physician.<br>Not covered: Exams for glasses, contact lenses, hearing aids, vision, hearing, speech, etc. | Eligible expenses for routine sight, hearing and speech covered at 60 percent after annual deductible when performed by physician.<br>Not covered: Exams for glasses, contact lenses, hearing aids, vision, hearing, speech, etc. | Eligible expenses for routine sight, hearing and speech covered at 80 percent after annual deductible when performed by physician.<br>Not covered: Exams for glasses, contact lenses, hearing aids, vision, hearing, speech, etc. |
| **Prenatal and Postnatal Obstetrical Care?** | **Office visits:** 100 percent after $20 copayment for first visit to obstetrician. No copayment for additional visits relating to the same pregnancy, if participant notifies HMO Blue Texas of the pregnancy in the first trimester. HMO Blue Texas must pre-approve Amniocentesis and Chorionic sampling. | **Office visits:** 100 percent after $30 copayment for first visit to obstetrician. No copayment for additional visits relating to the same pregnancy. | **Office visits:** 60 percent after annual deductible. | **Office visits:** 70 percent after annual deductible. |
| **Body Distortion Services?** | 100% after $20 copay. | **Office Visit**: 80% after $30 copay.<br>**Other Services:** 80% after annual deductible in outpatient setting. | **Office Visit:** 60% after annual deductible.<br>**Other Services:** 60% after annual deductible in outpatient setting. | **Office Visit**: 80% after annual deductible.<br>**Other Services:** 80% after annual deductible in outpatient setting. |
| | | $1,000 maximum per calendar year. (Includes all associated services: x-rays, lab, medicines) | | |
| **Inpatient hospital admissions?** | 100% after $500 copay per hospital admission. Pre-authorization required.<br>Note: Maternity admission requires $500 for mother with no additional copay for baby or babies, unless the baby is still hospitalized after the mother is discharged or readmitted because it is medically necessary. | 80% after $500 copay per admission. Pre-authorization required.<br>Note: Maternity admission requires $500 for mother with no additional copayments for baby or babies, unless the baby is still hospitalized after five days or readmitted because it is medically necessary. | 60% after $1,000 copay per admission. Pre-authorization required.<br>Note: Maternity admission requires $1,000 for mother with no additional copayments for baby or babies unless the baby is still hospitalized after five days or readmitted because it is medically necessary.<br>$250 copayment for failure to get pre-authorization. | 80% after $250 copay per admission. Pre-authorization required.<br>Note: Maternity admission requires $250 for mother with no additional copayments for baby or babies unless the baby is still hospitalized after five days or readmitted because it is medically necessary.<br>$250 copayment for failure to get pre-authorization. |
| **Hospital Emergency Room Charges per visit?** | $150 per visit (waived if admitted to the hospital). You must notify your PCP or HMO Blue Texas within 48 hours. Physician's office after hours: $20 per visit. | 80% after $150 copay for Emergency within 48 hours of Accident/Medical Emergency. Illness anytime. Copay waived if admitted to hospital.<br>80% after $150 copay for Emergency after 48 hours of the Accident/Medical Emergency. Copay waived if admitted to hospital. | 80% after $150 copay for Emergency within 48 hours of Accident/Medical Emergency. Illness anytime. Copay waived if admitted to hospital.<br>60% after $150 copay and deductible for Emergency after 48 hours of the Accident/Medical Emergency. Copay waived if admitted to hospital. | 80% after annual deductible. |
| **Minor emergencies?** If the condition is not serious enough to be a medical emergency, seek care through your physician, a participating Urgent Care Center or emergency care at the nearest medical facility. | **Office visits:** 100 percent after $20 copayment.<br>**Urgent Care Center:** 100 percent after $40 copayment. | **Office visits:** 100 percent after $30 copayment.<br>**Urgent Care Center:** 100 percent after $60 copayment. | **Office visits:** 60 percent after annual deductible.<br>**Urgent Care Center:** 60 percent after annual deductible. | **Office visits:** 80 percent after annual deductible.<br>**Urgent Care Center:** 80 percent after annual deductible. |
| **How does the plan cover surgery?** | **Ambulatory Surgery Facility:** 100% after $200 copay for each surgical procedure. Pre-authorization is Required.<br>**Inpatient:** 100% after $500 copay for each admission. | **Ambulatory Surgery Facility:** 80% after annual deductible for each procedure. Pre-authorization is Required.<br>**Inpatient:** 80% after $500 copay for each admission. Pre-authorization required. | **Ambulatory Surgery Facility:** 60% after annual deductible for each procedure.<br>**Inpatient:** 60% after $1,000 copay for each admission. Pre-authorization required. additional $250 copay if not preauthorized. | **Ambulatory Surgery Facility:** 80% after annual deductible for each procedure.<br>**Inpatient:** 80% after $250 copay for each admission. Pre-authorization required. $250 additional copay if not pre-authorized. |
| **Chemical Dependency Services?** | **Emergency room:** 100% after $150 copay per visit. Copay waived if admitted.<br>**Office Visit:** 100% after $20 copay.<br>**Inpatient:** 100% after $500 copay for each admission. Limited to 3 series of treatments per lifetime of individual. Pre-authorization required. | **Emergency room:** 80% after $150 copay. Copay waived if admitted.<br>**Office Visit:** 80% after $30 copay.<br>**Inpatient:** 80% after $500 copay for each admission. Limited to 3 series of treatments per lifetime of individual. | **Emergency room:** 60% after $150 copay & deductible. Copay waived if admitted.<br>**Office Visit:** 60% after annual deductible.<br>**Inpatient:** 60% after $1,000 copay for each admission.<br>$250 additional copay if not pre-authorized. | **Emergency room:** 80% after annual deductible.<br>**Office Visit:** 80% after annual deductible.<br>**Inpatient:** 80% after $250 copay for each admission. Limited to 3 series of treatments per lifetime of individual. $250 additional copay if not pre-authorized. |
| **Outpatient Mental Health services?** | **Office visit:** 100% after $25 copay per session. Maximum of 20 sessions per calendar year. | **Office Visit:** 80% after $30 copay. 30 visits maximum per calendar year. | **Office Visit:** 60% after annual deductible. 30 visits maximum per calendar year. | **Office Visit:** 80% after annual deductible. 30 visits maximum per calendar year. |
| **Inpatient Mental Health services?** | **In-patient:** If deemed medically necessary 100% after 20% copay per admission. 30 days maximum per calendar year. Pre-authorization required.<br>**Serious Mental Illness:** Covered as any other illness. 100% after $500 copay per admission. No limit on days of confinement. Pre-authorization required. | **In-patient:** 80% after $500 copay per admission 30 days maximum per calendar year.<br>**Serious Mental Illness:** 80% after $500 copay per admission. No limit on days of confinement. | **In-patient:** 60% after $1,000 copay per admission. 15 days maximum per calendar year.<br>**Serious Mental Illness:** 60% after $1,000 copay per admission. Pre-authorization required. $250 additional copay for no approval. No limit on days of confinement. | **In-patient:** 80% after $250 copay per admission. 30 days maximum per calendar year.<br>**Serious Mental Illness:** 80% after $250 copay per admission. Pre-authorization required. $250 additional copay for no approval. No limit on days of confinement. |
| **Physical therapy?** | 100% after $20 copay per visit. Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required. | Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required.<br>**Office Visit:** 80% after $30 copay per office visit.<br>**Outpatient:** 80% after deductible | 60% after deductible. Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required. | 80% after deductible. Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required. |
| **Private Duty Nursing?** | 100% if the PCP recommends the service and HMO Blue Texas pre-approve it. | 80% after annual deductible. Pre-authorization required. | 60% after annual deductible. Pre-authorization required. | 80% after annual deductible. Pre-authorization required. |
| **Allergy testing/serum and injections in Physician's office ?** | 50% copay for each physician office visit. Treatment for allergies, including testing, allergy serum and injections. | 80% after annual deductible without an office visit. Treatment for allergies, including testing, allergy serum and injections.<br>**Office visit:** 100% after $30 copay. | 60% after annual deductible. Treatment for allergies, including testing, allergy serum and injections. | 80% after annual deductible. Treatment for allergies, including testing, allergy serum and injections. |